NON-MEDICAL PROVIDER

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 620 (Rev. 06-2003)

Disclosure of the social security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in a $50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not to willful neglect.

Last Name, First, Middle Initial: (As it appears on your Social Security Card)			
Company Name: (As it is reported to the Internal Revenue Service)			
Mailing Address:	City:	State:	Zip Code:
Telephone Number:	County of Residence/Business:	Social Security or Federal Income Tax Number:	
Type of service you are providing: (Example: Transportation - to and from medical appointments, Lodging, Meals)			

List Your Medicaid Eligible Recipient(s): (At least one is required to enroll as a provider)

Last Name, First, Middle Initial:		Client's Medicaid Number:	
Mailing Address:	City:	State:	Zip Code:
Last Name, First, Middle Initial:		Client's Medicaid Number:	
Mailing Address:	City:	State:	Zip Code:
Are your Clients any Relation to You? ☐ Yes ☐ No	If Yes, Please Indicate the Relation to You:		
Do you Reside in the Same Household? ☐ Yes ☐ No	If so, is the Recipient a Foster Child or Adult? ☐ Yes ☐ No		

All Transportation Providers: You are required to submit with your application a copy of your current valid driver's license and proof of insurance.

Signature is required to complete the application process.

Signature	Date:

Please Send Completed Application To:

Medical Services
ND Department of Human Services
600 E Boulevard Ave - Dept 325
Bismarck ND 58505